DOCUMENT RESUME

ED 212 002 CS 503 704

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TITLE Recognition of Status Norms among the Non-Compliant Elderly: A Communication Course for Nurses.
PUB DATE Nov 81
NOTE 17p.; Paper presented at the Annual Meeting of the Speech Communication Association (67th, Anaheim, CA, November 12-15, 1981).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Behavior Standards; Communication Problems; *Communication Skills; *Inservice Education; Interaction; Interpersonal Relationship; Nurses; *Nursing; Older Adults; *Patient Education; Program Content; Program Descriptions; *Sensitivity Training

ABSTRACT

One important role performed by the hospital nurse is that of health teacher to elderly patients. Often nurses teach elderly patients the techniques of self-injection, how to monitor their dietary regimens, specialized hygiene techniques, and how to detect the physiological changes they may expect as a chronic disease advances. From the nurse's perspective, the efficacy of the teaching role may be hampered by elderly patients who ignore careful instructions, quiz the nurse about irrelevant matters, or shower the nurse with verbal or physical abuse. One cause of ineffective teaching interactions may be the nurse's inability to recognize the patient's salient norms, which include preferential treatment, empathy, acceptance of their "lay" assessment, and avoidance of derogatory labels. Communication specialists could meet the needs of the teaching nurse by offering a ten-session communication course for the systematic assessment of the salient norms the elderly patient might bring to the hospital. The sessions would focus on (1) a definition of norms, (2) verbatim techniques for gathering data, (3) the preparation for video taping data of norm violations, (4) reporting on the video tape sessions, (5) conducting a verbatim assignment, (6) preparing a norm profile, (7) practice with a surrogate patient, and (8) a final report on the encounters. (A sample verbatim practice is appended.) (HOD)

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RECOGNITION OF STATUS NORMS AMONG THE NON-COMPLIANT ELDERLY: A Communication Course For Nurses

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ABSTRACT

Older patients in a hospital setting often appear to disconfirm the role of the teaching nurse. Nurses may attribute this role rejection to hostility, irrationality, or confusion on the part of the patient. This paper argues that a supportive and cooperative teaching climate may be created if the nurse is sensitized to the salient status norms of the elderly patient. A method for teaching norm sensitivity is proposed.

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One of the important roles performed by the hospital nurse is that of health teacher for the elderly patient. She/he frequently teaches elderly patients such topics as: self-injection techniques, how the patient may self-monitor dietary regimens, what physiological changes the patient may expect as a chronic disease advances, and how to accomplish specialized hygiene techniques.

From the nurse's perspective, the efficacy of this teaching role may be hampered often by the elderly "non-compliant" patient who may appear to confound the best intentions of the nurse/teacher. In response to a nurse's careful instructions an elderly patient may ignore the nurse's directions, may quiz the nurse about matters irrelevant to the topic at hand, or may shower the nurse with verbal or physical abuse. Surveys of nursing literature and on-site observations conducted in hospitals, reveal that the non-compliant elderly patient represents a serious frustration for the teaching nurse.

Though many factors may contribute to this frustration, one cause of ineffective teaching interactions may be the nurse's inability to recognize the patient's salient norms. A nurse who was untrained in norm sensitivity may not recognize how and when the patient would be willing to be taught. If these patient norms are not acknowledged by the nurse, the patient will perceive that he/she is being disconfirmed and will be unlikely to cooperate with the nurse in teaching encounters.[1] By contrast, the more a patient's norms are acknowledged and confirmed by the nurse, the more the patient will feel that his/her values are accepted and the more he/she may elect at least partial cooperation with the nurse in the teaching scene.

This paper will describe some elder patient status norms which may be ignored unintentionally by the nurse. Further, this paper will suggest a hospital-based communication course designed to sensitize nurses to some of the norms of status salient to the elderly patient.

STATUS AND TREATMENT: One norm expectation which the elderly patient may bring to the healing scene is that of preferential treatment. Indeed, the American Nursing Association underscored this expectation and has developed care and treatment standards which emphasize individualized patient care particularly for the elderly (Browning 1974). In actual practice, however, geriatric nurses may often adopt care norms which appear to ignore individual differences in patient preferences, which require the patient to conform to institutional rules, and which urge the suppression of complaint (Coe, p. 324; Mechanic, pp. 335-349). When entering the hospital the elderly patient assumes that the nurse will give him/her individual care, yet he/she often receives uniform, "dispensed" care.

STATUS AND EMPATHY: The elderly patient's expectations of empathic treatment may be violated. The patient may assume the nurse will be sympathetic to his/her limitations of mobility, the high pain of chronic disorders, and worries about extended care when leaving the hospital. By contrast, Boorer (1970) finds that nurses often assume a "could not care less" attitude when dealing with elderly patients. Instead of gaining a sympathetic audience among nursing personnel, the elderly patient often finds the same subtle isolation inside the hospital as he/she experienced from society outside the hospital (Rudd 1967). The patient who expects the nurse to spend ample time with him/her conversationally exploring the

consequences of his/her physical condition may find that his/her nurse views such discourse as "idle chit-chat" (Stockwell 1972).

STATUS AND ASSESSMENT: Another norm the elderly patient may find violated is that of assessment of his/her condition. The patient may describe his/her condition for the nurse in terms rich with folk remedies, colorful (and perhaps inaccurate) causalities, and discursive reasoning. Usually the elderly patient may have several suggestions for diagnosis and cure of his/her condition. The nurse may counter these "layman's" assessments by explaining the patient's condition in the "right" terms. The nurse may try to correct these assessments with empirical explanations of the patient's condition. The nurse patronizingly assumes that the sheer weight of his/her logical, medical evidence will correct the patient's faulty perceptions (Bowers 1980; Billie 1977; Huckabay 1980).

STATUS AND LABELING: When the elderly patient does not meet the nurse's expectations of a cooperative patient, the nurse may lower the patient's status with derogatory labels. The patient who does not comply may be "irrational" (Hussar 1979), "disoriented" (Kroner 1979), "spoiled" (Coe 1978), or simply a "crock" (Scheff 1968). On-site interviews verify this practice. Fifty-three student nurses interviewed at the beginning of a communication course taught by the authors described older patients as demanding ("highly possessive of personal belongings," "giving explicit and petulant directions on how to store personal artifact"); as manipulative ("lies about other staff members," "spreads gossip about other nurses"); as rebellious ("uses abusive language," "became violent," "tells ribald jokes within earshot of visitors"); and as withdrawing ("won't talk with the nurses," "won't comply with treatments").

On the surface, the elderly patient appears to confound the nurse's teaching role by not complying with hospital and nursing norms. The problem may be solved if the nurse complied with the patient's status norms. If the nurse could be taught a systematic means of evaluating the norms and expectations the elderly patient brings to the hospital, then more effective teaching strategies could be molded to fit those expectations (Grimes and Stamps 1980; Wells 1980). Indeed, a few nursing sources suggest that such teaching strategies may be valid as seen in the roles of patients' advocates (Schwartz and White 1977), or as counselors in walk-in clinics for senior citizens (Grimes and Stamps 1980).

Given that a clear need exists for the nurse to teach the elderly patient more effectively, and given the fact that the elderly patient's status norms are often violated in the healing scene which prevent effective teaching, and given the fact that ANA dicta appear to prescribe sensitive recognition of the individual needs of the elderly patient, it would appear that communication specialists could meet the need of the teaching nurse by constructing a communication course for the systematic assessment of the salient normative constructs which the elderly patient might bring to the hospital scene. Such a course is described below. This ten session course (two hours per session) is designed for hospital in-service training of nurses. The materials which the course would use, could be found in the inventory of most modern hospitals. The course instructor would be a communication specialist.

SESSION I: Definition of Norms

The students would be introduced to the concept of norms. Since nurses

possess a rich physiological educational orientation, norms should be described in the terms which the nurses can understand best:

> You know that certain diseases have distinct ways of affecting patients' behaviors. For example, you know that emphysema victims often have brittle temperaments or that diabetics often have the "habit" of disregarding the seriousness of their condition. You have seen these patterns of behaviors associated with various diseases. When you see certain diseases, you have learned to expect certain patterns of behavior arising from that condition. In a similar way, outside the realm of medicine, certain behavior patterns can be expected from persons who have specific mind-sets, biases, or attitudes that they wish to express. These patterns of behavior can be called norms.

The students may discuss the behaviors they have observed with various diseases and expand on the two examples given above. At this point the instructor will introduce a catalogue of norms. The normative constructs described in Knapp (1978) are helpful for the nurses and easily adaptable to the medical scene. These constructs are:

1. Persons in close proximity to each other, demand more personal messages; persons speaking at a distance demand more public messages.

2. Persons who have an extended personal relationship demand more endearing titles; persons with a short relationship demand more formal titles.

3. Persons of high status demand messages of humility from persons of lower status; persons of low status demand dignity messages from persons of higher status.

4. Persons with high ego involvement in the topic demand respect messages; persons with low ego involvement in the topic demand non-dramatic, non-pretentions messages.

5. Speakers with high role clarity should send messages consistent with that role; persons with low role clarity should send non-pretentious

messages. Supply illustrations of each of these norm constructs from outside the hospital environment and from within the hospital setting. In group discussion sessions, have the class identify additional scenes within the hospital where these norms are violated. The point of the course can be made at the conclusion of the discussion: the more the speaker's messages are congruent to the norms of the receiver, the more likely the receiver is to conform to the speaker's perspective.

Assignment: The students are to listen for norm violations among staff members or patients and write these violations down for class consideration in the next session.

SESSION II: Verbatim Technique

The students are given a means for gathering data which will be used in later exercises. The verbatim is a simple notation technique in which the observer writes down one word from each phrase overheard in a conversation. At the conclusion of the conversation, the observer reconstructs the conversation from the notes which have been taken. The students may practice this technique using the script supplied in the Appendix. The students should use stenographer's pads with divided pages. The students may use one half of the page for the notes and the other half for the reconstructed discourse. Read the script slowly at first. Stop at the marked lines in the script in order to have class members repeat their reconstruction. They will be surprised at the quality of their recall. After several sessions with a prepared script, ask for several members of the class to construct dysfunctional dyads for practice of a "live" interaction.

Assignment: The students are to write a verbatim of a norm violation

activity they observe while on duty in the hospital and bring the verbatim to the next class for discussion.

SESSION III: Preparation for Video Taping

The class will discuss the verbatims of norm violations gathered from the staff. Select one or two of the verbatims and ask the class for suggested responses which might be more congruent with the normative constructs the receiver of the violation might have expressed in his/her discourse. Now the class is asked to gather data of norm violations among the staff by video taping techniques. Introduce the use and operation of the video tape recorder. Divide the group into two sections. Each group is to video tape the behavior of staff members at the nurses' station. The use of two video recorders would be ideal. One recorder could be placed unobtrusively at a station where the nurses are known to have good relations, and one recorder could be placed at a station where the nurses are known to have staff friction. Permission for this recording can be obtained from the Director of Nursing as long as the tapes will be used only for instruction, and as long as a majority of the recorded interactions do not photograph patients. The students are to tape one hour of discourse at the station(s) during the busy hours of the morning. After the hour of taping is complete, the team members are to review the tape and note by the footage indicators on the play-back equipment, where the norm violations occur. Students may practice using the video tape equipment prior to the actual taping.

SESSION IV Video Taping the Station(s)

SESSION V: Report On The Video Tape Sessions

Each team will present the tape coverage they have made and identify

the norms that have been violated at the station(s). Ask open-ended questions for discussion: How do you think the receiver felt when his/her norms were broken? What attitude did the receiver try to protect by his initial hostile response? What attitude did he/she succeed in projecting to the sender as a result of this violation? What amount of compliance could the sender expect from the receiver when there was a norm violation in this scene? What would be a more supportive way the sender could have crafted his/her message? Conclude this discussion with the open question: What compliance level could be expected from the patient whose norms are violated? To answer this question, nurses as pairs are asked to identify an elderly patient who has been non-compliant in the past and who has frustrated the nurse's efforts at tracking. The nurses are to sit outside the room of the patient they have identified and record by verbatim technique the exchanges occurring in the patient's room over a two hour period.

SESSION VI: The Verbatim Assignment

Students as pairs spend two hours gathering the data on their designated patient. The nurses will attract little attention if they use a tray table for a writing desk as they take the verbatim. It will appear they are filling out documentation reports and will be avoided by sympathetic staff members. Pairs of nurses are used for each case in order that the quality of the data can be verified.

SESSION VII: Preparing For The Norm Profile

The students return to the classroom setting and compare the norms which they have observed in violation with their patients. Ask open-ended discussion questions: What images did the patient obtain of the norm violator?

What self-image was the patient trying to protect by his/her hostile response? How readily did the patient comply with other nurses when his/her norms were violated? What ways did the patient use to register objection to the norm violation? What were some facets of this patient's background which would help a nurse understand the norms brought to the hospital? In answer to this last question, each pair of nurses is to write a "Norm Profile" on the background of their patient. The nurses are to use hospital records and interviews to supply data and clues as to the patient's self-image. The nurses are to search through patient records for any clues as to the background of the patient: occupation, status in the community, associations, significant others, religious background, etc. Further, the nurses are to interview one of the family members of the patient for additional information. It is suggested that they begin this inverview with: "In order that we might serve (patient's name) better here at the hospital, could you please tell us what are (patient's name) likes and dislikes when he is at home and feeling well?" The nurses are to note psychological constructs which may emerge from these interviews: status, work satisfaction, affiliate relationships, previous experience in the hospital, how the patient views hospitalization, tolerance toward ambiguity, attitudes toward authority, leadership role in the community, salient conversational topics, etc. Further, the nurses are to interview a "significant other" in the patient's life, and ask the same questions as listed above. At the end of these interviews the nurses are to write a norm profile entitled, "What Patient (name) Will Expect of ME As His/Her Nurse."

SESSION VIII: Norm Profile Interviews and Writing

SESSION IX: Practice With The Surrogate Patient

Nurses are to return to the classroom and share the norm profiles that each team has written about their patient. Based on the profile they have written on their patient's expectations, the nurses practice their norm sensitive discourse on a surrogate patient (hospital counselor) who will role play hostile scenes.

Assignment: Begin norm sensitive discourse with the patient identified in the norm profile.

SESSION X: Report On Encounters

The nurses return to the classroom and compare the results of their interactions with their patients. The class of nurses should not be disbanded at the completion of this series of exercises but should become a permanent forum where nurses might systematically evaluate patient expectations. Skills and techniques learned by teaching the older patient would certainly apply to other patients the nurse might encounter in his/her practice.

> As every good teacher knows, the business of teaching is not that of penetrating the student's defenses with tne violence or loudness of the teacher's messages. It is, rather, that of cooperating with the student's own inward teacher whereby the student's image may grow in conformity with that of his outward teacher (Boulding 1977).

APPENDIX

Verbatim Practice

Pt: Nurse, can you help me a minute?
RN: WELL, WE'LL SEE - WHAT IS IT YOU NEED?
This IV bottle thing is just about dry.
THERE'S STILL A BIT MORE LET IN IT -WHAT'S THE PROBLEM?

Well (indignantly) I don't want it to run dry and pump air into my veins.
THAT'S NOT POSSIBLE - DON'T BE CONCERNED ABOUT THAT.
There's no need to be snippy about it -- I'm only trying to help you girls out. You wouldn't want a patient to die on you, would you?
THANK YOU FOR YOUR CONCERN - WE'RE PERFECTLY CAPABLE OF MANAGING YOUR HEALTH CARE.
Well mistakes do happen - but of course you're being paid not to make mistakes - paid pretty well from what I read.
DON'T BELIEVE EVERYTHING YOU READ. NURSES ARE ALWAYS UNDERPAID.

That's what every worker says -- everybody thinks they are underpaid.
(Irritated) WILL THERE BE ANYTHING ELSE, MR. MANDIBLE?
Can't you take this thing off me?
NOT UNTIL YOUR DOSAGE IS COMPLETE.
But my arm is getting so tired holding it in this one spot--can't you do something? I gotta get some relief?
YOU HAD BETTER GET USED TO IT, BECAUSE YOUR PHYSICIAN HAS ORDERED ANOTHER BOTTLE FOR YOU THIS AFTERNOON.
What!
THAT'S RIGHT. PHLEBITIS IS VERY SERIOUS. WE MUST BE SURE THAT YOU"RE NOT GOING TO CLOT ON US.

Well, if I had known that I was going to be tortured like this 24 hours a day I would have stayed home and died.
THAT MIGHT HAVE HAPPENED.
It would be a lot easier than putting up with this monkey business.
I'M SURE YOU WOULDN"T WANT TO DIE MR. MANDIBLE. IT WILL BE A LOT EASIER ON YOU IF YOU JUST TRY TO RELAX AND LET THE HEPARIN WORK.
Relax, relax, relax...that's what everyone tells me. I could have done that at home.
YOU ARE GETTING THE BEST CARE POSSIBLE HERE...WE WANT YOU HERE SO WE CAN KEEP AN EYE ON THIS CONDITION OF YOURS.
It seems to me that I'm paying for an awful lot of people around here just to keep an eye on me. My wife at home could have done the same thing.
I'M NOT GOING TO ARGUE THIS WITH YOU MR. MANDIBLE. WILL THERE BE ANYTHING ELSE?

Oh sure -- just leave me here to die, now that you've upset me like this.

MR. MANDIBLE, IT WAS NOT I WHO STARTED THIS ARGUMENT.

Oh, it's an argument now -- I came here for peace and quiet and I get nothing but arguments from you high priced nurses around here.

MR. MANDIBLE, I AM SURE THAT YOU DON'T MEAN THAT. WE HAVE GIVEN YOU THE BEST CARE AVAILABLE IN THIS CITY. I WILL MATCH MY NURSES HERE AT MEGAMAYO CLINIC OVER AGAINST ANY IN THIS CITY.

Yeah, and I'm paying through the nose for you girls...while you torture me like some stuck pig.

MR. MANDIBLE!

Don't Mr. Mandible me -- get these tubes out of me - I'm going go home.

YOU ARE NOT GOING HOME. NOW LIE DOWN AND BEHAVE YOURSELF!

Well, who do you think you are talking to me like some little kid???

YOU SAID IT!

FOOTNOTE

[1]Beyond the gerontological scene, communication literature argues that messages which are congruent with a receiver's normative expectations have higher credibility in the receiver's mind. J. Shannon and B. Guerney ("Interpersonal Effects of Interpersonal Behavior," Journal of Personality and Social Psychology, 26:1 (1973), 142-150) posit that communicatively competent persons are those who can recognize psychological patterns in the discourse of the message sender. J. M. Wiemann ("Explication and Test of a Model of Communicative Competence," Human Communication Research, 3:3 (1977), 195-213) extends this proposal by arguing that communicatively competent persons not only recognize patterns in the discourse of others, and can identify the psychological needs inherent in those patterns, but can respond to those needs in an empathic manner. R. P. Hart, R. E. Carlson, and W. F. Eadie ("Attitudes Toward Communication and the Assessment of Rhetorical Sensitivity," Communication Monographs, 47:1 (1980), 1-22) build on Shannon, Guerney, and Wiemann by positing that the "rhetorically sensitive" person is he who accepts personal complexity in the other, avoids rigidity, appreciates exchange of ideas, is conscious of meaning exchange, and tolerates inventional searching. These same theoretical communication competencies appear to be operationalized in the gerontological literature by named skill needs which gerontological staff members should have. W. M. Beattie ("The Relevance of Communication for Professionals Involved With The Elderly: Focus on Social Workers," in H. J. Oyer and E. J. Oyer, (eds.) Aging and Communication (Baltimore: University Park Press, 1976), pp. 239-251) proposes that all gerontological helping professionals should have "translator" skills which help to articulate the institutionalized elderly's views to those who are not institutionalized. C. J. Bininger and M. Kiesel ("Assessment of Perceived Role Loss in the Gerian," Journal of Gerontological Nursing, 4:5 (1978), 24-27) argue that specialists need to be trained to assess the amount of role loss the elderly patient may feel when hospitalized. S. Eisenthal ("Adherence and the Negotiated Approach to Patienthood," Archives for General Psychiatry, 36:4 (1979), 393-8) argues that gerontological specialists need training in urging the elderly patient to participate in the planning of his/her own health care regimen in order to increase compliance with that regimen. D. C. Jones("Spatial Proximity, Interpersonal Conflict, and Friendship Formation," Gerontologist, 15:2 (1975), 150-4) argues that specialists need to be trained in recognizing the norms associated with spatial distance in order to reduce conflict in nursing homes. The gerontological literature appears to cite explicit career needs which the communication specialist was was trained in norm sensitivity could fill.

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